Government of the District of Columbia
Department of Health

HEALTH REGULATION AND LCENSING ADMINISTRATION
BOARD OF MEDICINE

MEDICAL TRAINING REGISTRANT FORM
(Medical Resident Rotations of 90 days or less)

■ **STOP: BEFORE COMPLETING THIS FORM, PLEASE REFER TO APPLICATION INSTRUCTIONS.**

■**ALL APPLICANTS ARE REQUIRED TO UNDERGO A CRIMINAL BACKGROUND CHECK PER DC OFFICIAL CODE SECTION 3-1205.22.**
For payment and to schedule an appointment Call **1-877-783-4187** or www.L1enrollment.com

■**ATTACH A COPY OF A GOVERNMENT ISSUED PHOTO ID.**

■**THIS FORM MUST BE RECEIVED BY THE DC BOARD OF MEDICINE AT LEAST 30 DAYS PRIOR TO START DATE.**

■**THERE IS NO FEE ASSOCIATED WITH THIS APPLICATION.**

SECTION 1. MEDICAL TRAINING REGISTRANT INFORMATION

Note: LEGAL NAME: ***(Do not use any initials unless they are a part of your name)***

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

DEGREE(S): ☐ **M.D.,** ☐ **D.O,** ☐**PH.D.,** ☐ **MBBS** ☐ **OTHER DEGREE**_____

____/_____/_____ _____ - _____ - _____
Date of Birth **Social Security Number** **GENDER:** ☐ **MALE** ☐ **FEMALE**

PHONE NUMBER: (_____**)** _____ **-** _____ **EMAIL ADDRESS (REQUIRED) :** _____

SECTION 2. MEDICAL TRAINING BACKGROUND

NAME OF MEDICAL SCHOOL ATTENDED: _____ **COUNTRY:**_____ **GRADUATION DATE:** _____

NAME OF CURRENT RESIDENCY TRAINING PROGRAM INSTITUTION:_____ **STATE:** _____

YEAR OF POSTGRADUATE TRAINING: ☐ **PGY1** ☐ **PGY2** ☐ **PGY3** ☐ **PGY4** ☐ **PGY5** ☐ **PGY6** ☐ **OTHER:** _____

SECTION 3. SELECT DC ROTATING HOSPITAL

ROTATIONS MAY NOT EXCEED MORE THAN 90 DAYS IN AN ACADEMIC TRAINING YEAR.

☐ **CHILDREN'S NATIONAL MEDICAL CENTER** ☐ **MEDSTAR GEORGETOWN UNIVERSITY HOSPITAL** ☐ **PROVIDENCE HOSPITAL**

☐ **GEORGE WASHINGTON UNIVERSITY HOSPITAL** ☐ **MEDSTAR NATIONAL REHABILITATION HOSPITAL** ☐ **ST. ELIZABETH'S HOSPITAL**

☐ **HOWARD UNIVERSITY HOSPITAL** ☐ **MEDSTAR WASHINGTON HOSPITAL CENTER** ☐ **UNITY HEALTH CARE**

DATES OF ROTATION: START DATE: _____/_____/_____ **END DATE:** _____/_____/_____

SECTION 4. AFFIDAVIT

I hereby attest that I am in good academic standing at my current residency training institution and the information given in this Medical Training Registrant Form is true and complete to the best of my knowledge. I understand that making a false statement on this Form is punishable by criminal penalties.

_____ _____ _____
REGISTRANT SIGNATURE **PRINT NAME** **DATE**

PRINT THIS REGISTRANT FORM AND MAIL TO THE DC BOARD OF MEDICINE. PLEASE RETAIN A COPY FOR YOUR FILES.